# SUSTAINABLE DEVELOPMENT GOALS REGARDING MATERNAL MORTALITY AND NATIONAL HEALTH MISSION: A STUDY OF UTTAR PRADESH

A

Synopsis

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## 1.0 INTRODUCTION

In India, both the central and state government acquire the health care expenditure. According to the Indian constitution the principal control of providing health care lies with the state government and most of the health expenditure in the country is acquire by them. The central government includes to the state's expenditure in sector that are of national interest and are correlated with high level. Until the period of mid-nineties, the central government acquired expenditure principally on family planning, advancement of medical education in national level institute and regulatory bodies, preferred disease supervision programs tertiary level health care, research and training. Increased funding by donors and expenditure resulted in the high expenditure on maternal and child health, and disease control programs, since the late nineties.

Recently, by the commencement of National Rural Health Mission, the center has also started to provoke a considerable amount of expenditure on primary and secondary health care at the state level. In the middle of 2000 and 2009, the contribution of center in entire health expenditure of the nation has expanded from around 15 to 30 percent.

Maximum development in health expenditure by the center has been in the structure of direct expenditure at the state-level. Before the commencement of NHRM and development of donor financed health programs, majority of health expenditure through the center placed at the state level was acquired by the state finances. Expenditure, which was of outside the state finances acquired usually on self-governing institution and centrally funded health facilities placed in the state. To implement schemes inaugurated by the central government, numerous numbers of agencies and self-governing bodies have been established at the state level, this took place in recent years, especially with the scaling-up of donor funded projects. This was executed in order to minimize postponement in relocation of funds from center to states for execution of central-area schemes which are centrally subsidized.

## 1.1 SUSTAINABLE DEVELOPMENT GOALS - GOOD HEALTH AND WELL-BEING

India has made some progress in reducing its under-five mortality rate, which declined from 125 per 1,000 live births in 1990-91 to 50 per 1,000 live births in 2015-16, and its maternal mortality rate, which declined from 212 per 100,000 live births in 2007-09 to 167 in 2013. India has also made significant strides in reducing the prevalence of HIV and AIDS across different types of high-risk categories, with adult prevalence reducing from 0.45% in 2002 to 0.27% in 2011. However, a quarter of global TB cases occur in India where nearly 2.1 million people live with the disease, and an estimated 423,000 die annually as a result. The Indian government's National Health Mission priorities national wellbeing and is leading change in this area, in addition to targeted national programs against HIV/AIDS and sexually transmitted diseases.

## 1.2 MILLENNIUM DEVELOPMENT GOAL

A meeting of representatives of 189 countries took place at the Millennium Summit in September 2000, committing their nations to a new global partnership to reduce extreme poverty and setting out a series of time bound targets, with a deadline of 2015 that have become known as the Millennium Developmental Goals (MDGs). There are eight goals under MDGs, where Goal No. 4 is dedicated to reduce child mortality.

**Table No.1: Targets for Goal 3**

| S.No. | TARGETS FOR GOAL 3 | INDICATOR |
|---|---|---|
| 1. | By 2030, Reduce the global Maternal Mortality ratio. | • MMR<br>• Births attended by skilled health professional |
| 2. | By 2030, aims to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births. | • Under-five mortality rate (U5MR)<br>• Neonatal Mortality rate (NMR) |
| 3. | By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. | • Number of new HIV infections per 1000 uninfected population, by sex, age and key populations.<br>• Tuberculosis incidence per 1000 Population.<br>• Malaria incidence per 1000 population at risk.<br>• Hepatitis B incidence per 100000 population.<br>• Number of people requiring intervention against neglected tropical diseases. |

| | | |
|---|---|---|
| 4. | By 2030, reduce premature mortality form non-communicable diseases by one third and promote mental health and well-being | • Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70.<br>• Suicide mortality rate. |
| 5. | Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. | • Coverage of treatment interventions for substance abuse<br>• Alcohol per capita consumption (>15 years of age) within a calendar year in litres of pure alcohol. |
| 6. | Half the number of global deaths and injuries from road traffic accidents. | • Death rates due to road injury per lac population |
| 7. | By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning. | • Proportion of married or in- union women of reproductive age who have their need to family planning satisfied with modern methods (%).<br>• Adolescent birth rate per 1000 women of 15-19 Years. |
| 8. | Achieve universal health coverage | |
| 9. | By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination. | • Mortality due to air pollution<br>• Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe WASH services)<br>• Mortality rate attributed to unintentional poisoning. |
| 10. | Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate. | • Age- standardized prevalence of current tobacco use among persons aged 15 years old. |
| 11. | Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines. | • Proportion of population with access to affordable medicines and vaccines on a sustainable basis.<br>Total net official development assistance to medical research and basic health sector. |
| 12. | Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing states. | Health work Density and distribution. |
| 13. | Strengthen the capacity of all countries, for early warning, risk reduction and management of national and global health risks. | International Health Regulation (IHR) capacity and health emergency preparedness index. |

## 1.3 MATERNAL MORTALITY

MM is the maternal death of a woman in India during pregnancy or after birth. Different countries and cultures have different rates and causes for maternal death. In India there is also variation in these things for the various states, regions, and demographics of women.

## 1.4 PUBLIC HEALTH INITIATIVES

The Government of India has started various public health initiatives to provide a safe and secure environment. Some of these initiatives are

- Janani Suraksha Yojana (JSY),
- Pradhan Mantri Matru Vandana Yojana (PMMVY),
- Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)
- Poshan Abhiyan and Laqshya

Government has also taken initiatives on improving the infrastructure of the country by improving roads and providing free ambulance services at PHC.

## 1.5 NATIONAL HEALTH MISSION (NHM)

The **National Health Mission** (**NHM**) was launched by the government of India in 2013 subsuming the National Rural Health Mission and National Urban Health Mission. It was further extended in March 2018, to continue until March 2020. It is headed by Mission Director and monitored by National Level Monitors appointed by Government of India.

The National Rural Health Mission (NRHM), now under National Health Mission is an initiative undertaken by the government of India to address the health needs of under-served rural areas. Launched on 12 April 2005 by then Indian Prime Minister Manmohan Singh, the NRHM was initially tasked with addressing the health needs of 18 states that had been identified as having weak public health indicators. The Union Cabinet headed by Dr. Manmohan Singh vide its decision dated 1 May 2013, has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an overarching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission.

Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on

outcomes, measured against Indian Public Health Standards for all health facilities. As per the 12th Plan document of the Planning Commission, the flagship programme of NRHM will be strengthened under the umbrella of National Health Mission. The focus on covering rural areas and rural population will continue along with up scaling of NRHM to include non-communicable diseases and expanding health coverage to urban areas. Accordingly, the Union Cabinet, in May 2013, has approved the launch of National Urban Health Mission (NUHM) as a sub-mission of an overarching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other sub-mission of the National Health Mission.

It was further extended in March 2018, to continue till March 2020.

There are some indicatives:

- Community Health volunteers called Accredited Social Health Activists (ASHAs) have been engaged under the mission for establishing a link between the community and the health system. ASHA is the first port of call for any health-related demands of deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas. ASHA Programme is expanding across States and has particularly been successful in bringing people back to Public Health System and has increased the utilization of outpatient services, diagnostic facilities, institutional deliveries and inpatient care.
- The Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society is a management structure that acts as a group of trustees for the hospitals to manage the affairs of the hospital. Financial assistance is provided to these Committees through untied fund to undertake activities for patient welfare.
- NRHM has provided health care contractors to underserved areas, and has been involved in training to expand the skill set of doctors at strategically located facilities identified by the states. Similarly, due importance is given to capacity building of nursing staff and auxiliary workers such as ANMs. NHM also supports co-location of AYUSH services in Health facilities such as PHCs, CHCs and District Hospitals.

## 2.0 REVIEW OF LITERATURE

**Suhad Daher-Nashif (2020)**[1] In 2014, United Nations member states proposed a set of sustainable development goals SDGs) to help further the millennium development goals that they had proposed in New York in 2000. Of these 13 SDGs, Goal 3 (i.e., SDG 3) was titled "Good Health and Well-Being." This goal highlighted women's health and well-being via two key objectives. The first, SDG 3.1, aimed to reduce maternal mortality rates (MMR) and the second, SDG 3.7, aimed to ensure access to sexual and reproductive health care services. The paper aims to review GCC states' work on women's wellbeing in SDG3, which achievements they obtained, which tools they used and which gaps still exist and to explain the socio-cultural background behind these achievements, tools, and gaps. For the purpose of this study, they used narrative review approach through which they reviewed reports from 2017 and 2018 on SDGs published online by the Ministry of Development and Planning of each GCC state, and latest reports of the WHO on the same states. Findings: the study found similarities and differences between different GCC states, which in turn reveals gaps and areas that are not meeting women's needs. The findings show that MMR in GCC countries has declined by nearly half. The paper concludes that there is a much greater emphasis on reducing MMR, compared to providing access to sexual and reproductive healthcare.

**Anuska Kalita (2015)**[2] Public health research has gained increasing importance in India's national health policy as the country seeks to address the high burden of disease and its inequitable distribution, and embarks on an ambitious agenda towards universalizing health care. This study aimed at describing the public health research output in India, its focus and distribution, and the actors involved in the research system. It makes recommendations for systematically promoting and strengthening public health research in the country. In total, 67.2% of papers involved international collaborations and 49.2% of these collaborations were with institutions in the UK or USA; 35.4% of the publications involved international funding and 71.2% of funders were located in the UK or USA. While public health research output in India has increased significantly, there are marked inequities in relation to the burden of disease and the geographic distribution of research. Systematic priority setting, adequate funding, and institutional capacity building are needed to address these inequities.

**Mohammad Baharuddin (2019)[3]** To determine the factors contributing to hospital-based maternal deaths in, Indonesia, given most women deliver with skilled birth attendants and in health facilities.

A retrospective review of case records examined quality of care issues related to maternal mortality in hospital settings. The review abstracted information from blinded medical records of 90 women who died in 11 hospitals from January to June 2014. Specialists from the Indonesian Society of Obstetrics and Gynecology reviewed abstracted records to determine causes of death and identify contextual factors for these deaths. Human resource/health worker factors were more frequently identified than supply, facility, or infrastructure factors. Ninety percent of maternal deaths were classified as preventable. The review exercise yielded useful information on factors contributing to preventable maternal mortality in hospitals in Indonesia. Results helped focus quality improvement efforts and increased awareness of the value of routine, in-depth facility-based maternal death reviews.

**Tadele Girum (2017)[4]** Maternal mortality is a major public health issue in developing countries due to its shocking magnitude and lower declining pattern. This study aimed to identify correlates of maternal mortality in developing countries. The dependent variable was the maternal mortality ratio, while the independent variable was socio-economic, health care related and morbidity variables. Maternal mortality ratio is very high in developing countries and enormously varies among countries. A significant relationship between the maternal mortality ratio and socio-economic, health care and morbidity indicator variables were observed. There was an inverse and significant correlation of the maternal mortality ratio with Antenatal care coverage, skilled birth attendance etc. Maternal mortality is correlated with multiples of socio-economic factors, health care system associated factors, disease burden and their complex interactions. Therefore, Policy and programs targeted to improve maternal health and reduce maternal deaths should consider population dynamics, socio-economic influence and health system factors that impose a major risk on mothers.

**Melissa Bauserman (2015)[5]** Prospective of this study was, population-based data sets describing maternal outcomes are typically not available in low- and middle-income countries, it is difficult to monitor maternal mortality rates over time and to identify factors associated with maternal

mortality. Early identification of risk factors is essential to develop comprehensive intervention strategies preventing pregnancy-related complications. Objective was to describe maternal mortality rates in a large, multi-country dataset and to determine maternal, pregnancy-related, delivery and postpartum characteristics that are associated with maternal mortality. They observed an improvement in the total MMR from 166 in 2010 to 126 in 2013. The MMR in Latin American sites (91) was lower than the MMR in Asian (178) and African sites (125). The Maternal and Neonatal Health Registry (MNHR) identified preventable causes of maternal mortality in diverse settings in low- and middle-income countries. The MNHR can be used to monitor public health strategies and determine their association with reducing maternal mortality.

**Lale Say (2014)**[6] Data for the causes of maternal deaths are needed to inform policies to improve maternal health. They developed and analyzed global, regional, and sub-regional estimates of the causes of maternal death during 2003–09, with a novel method, updating the previous WHO systematic review. On the basis of pre specified inclusion criteria, we analyzed causes of maternal death from datasets. They aggregated country level estimates to report estimates of causes of death by Millennium Development Goal regions and worldwide, for main and sub causes of death categories with a Bayesian hierarchical model. More than a quarter of deaths were attributable to indirect causes. These analyses should inform the prioritization of health policies, programmes, and funding to reduce maternal deaths at regional and global levels. Further eff orts are needed to improve the availability and quality of data related to maternal mortality. USAID, the US Fund for UNICEF through a grant from the Bill & Melinda Gates Foundation to CHERG, and the UNDP/UNFPA/UNICEF/WHO/The World Bank Special Programme of Research, Development, and Research Training in Human Reproduction (HRP), Department of Reproductive Health and Research.

**Nizamuddin Khan (2013)**[7] Maternal mortality has been identified as a priority issue in health policy and research in India. The country, with an annual decrease of maternal mortality rate by 4.9% since 1990, now records 63,000 maternal deaths a year. India tops the list of countries with high maternal mortality. Based on a verbal autopsy study of 403 maternal deaths, conducted in 2008, this paper explores the missed opportunities to save maternal lives, besides probing into the

socioeconomic factors contributing to maternal deaths in Jharkhand, India. The analytical approach includes bivariate analysis using SPSS 15, besides triangulation of qualitative and quantitative findings. Delays in decision-making, travel, and treatment compounded by ignorance of obstetric complications, inadequate use of maternal healthcare services, poor healthcare infrastructure, and harmful rituals are the major contributing factors of maternal deaths in India.

**Nancy L. Sloan (2001)[8]** Their objectives are to reassess the practical value of verbal autopsy data, which, in the absence of more definitive information, have been used to describe the causes of maternal mortality and to identify priorities in programmes intended to save women's lives in developing countries. They reanalyzed verbal autopsy data from a study of 145 maternal deaths that occurred in Guerrero, Quere´taro and San Luis Potosı´, Mexico, in 1995, taking into account other causes of death and the WHO classification system. The results were also compared with information given on imperfect death certificates. The reclassification showed wide variations in the attribution of maternal deaths to single specific medical causes. The verbal autopsy methodology has inherent limitations as a means of obtaining histories of medical events. At best it may reconfirm the knowledge that mortality among poor women with little access to medical care is higher than that among wealthier women who have better access to such care.

**K. Sharma (2018)[9]** National Rural Health Mission (NRHM- 2005-07) has been viewed as the holistic and democratic mission mode intervention by the state in the field of health. It is based on innovative and comprehensive strategies for providing funds, creating new institutions, decentralization and providing new ideas and resources for health. Assuming the importance of NRHM in improving general health conditions and in particular improvement in IMR and MMR the state has extended it further till 2017. The Twelfth Five Year Plan has also extended NRHM to urban poor, calling it a National Health Mission (NHM) rather than National Rural Health Mission (NRHM). This paper examines the goals and strategies of NRHM and discusses its strengths and weaknesses. At the end it suggests that to make health interventions effective there is a need to strengthen the primary health care system in both rural and urban areas. Weakening of the primary health care system due to multiple priorities and transfer of responsibility to private sector in the new-liberal regime may do a severe damage to the health system.

**Mrs. Balamani V K (2018)**[10] The present paper attempts to analyse the impacts of National Rural Health Mission (NRHM) on the people of Kerala. Kerala Health Model which is discussed and impressed world-wide with its sophistication and classiness and with established and satisfactory health outcomes undoubtedly materialized and upgraded with operation of this policy. This paper tries to investigate the present-day challenges for the NRHM and ways to go through to improve the Kerala Health Model by synthesizing the core aspects of the policy and needs of the community. NRHM has completed its 12 functional year in 2017. It started as a mission from 2005 to 2012. There is positive impact over the people of India. Earlier it considered the rural area as the aim, then National Urban Health Mission (NUHM) was added over it targeting urban areas but now it is an overall policy under the umbrella name of National Health mission (NHM).

**Madhu Gupta (2017)**[11] A multi-pronged community-based strategy, known as National Rural Health Mission (NRHM), was implemented from 2005–06 to 2012–13 in India to curtail maternal and child health (MCH) disparities between poor and rich, rural and urban areas, and boys and girls. This study aimed to determine the degree to which MCH plans of NRHM implemented, and resulted in improving the MCH outcomes and reducing the inequalities. A logistic regression analysis was done for quantitative data, and inductive applied thematic analysis for qualitative data. The findings of the quantitative and qualitative parts of study were mixed at the interpretation level. MCH plans of NRHM might have succeeded in improving the MCH outcomes and reducing the geographical and socioeconomic MCH inequalities by successfully implementing the schemes like accredited social health activists, free ambulance services, free treatment and medicines in hospitals for the poor and in rural areas.

**Zakir Husain (2014)**[12] The National Rural Health Mission was introduced as a flagship scheme of the United Progressive Alliance government in 2005-06 to address the needs of the rural population through an architectural correction of the health system. The need for a concerted targeting of rural India led the government to introduce the National Rural Health Mission (NRHM) as its health flagship scheme in 2005. The objective of this scheme was to "carry out necessary architectural correction in the basic health care delivery system … to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women

and children" (GOI 2005: 1). This objective is sought to be attained through strategies aimed at improving household health status through the introduction of female health activists, strengthening the three-tiered public health system, increasing community participation through the involvement of Panchayati raj institutions (PRIs) and strengthening capacities for data collection to facilitate evidence-based planning, monitoring and supervision. With the deadline of this scheme drawing to a close in 2012, it is an appropriate time to undertake an evaluation of the success of the NRHM. Three common review missions (CRMs) have been completed. The population research Centres (PRCs) have undertaken a first-round evaluation of the mission based on rapid appraisal methods in select districts on behalf of the Ministry of Health and Family Welfare. Evaluation studies undertaken by the Planning commission, the Ministry of Health and independent authorities indicate that the situation in terms of quantitative goals and quality of service in many states leaves much to be desired. With the mission nearing its deadline in 2012, it is unlikely that unfinished tasks can be completed within the remaining period.

**Suresh Kumar Patra (2013)[13]** An agrarian structure predominated by small and marginal farmers; and repeated natural calamities like droughts, floods and cyclones and poor infrastructural development in the hilly terrain of western and southern Odisha have an adverse effect on the health status of the people of Odisha. As a result of which the birth rate, death rate, infant mortality rate, life expectancy rate, maternal mortality ratio, total fertility ratio, etc., of Odisha lags behind the national average. To improve the prevailing situation, the Government of Odisha launched the National Rural Health Mission (NRHM) programme in the state on 17 June 2005. The NRHM has completed six years in Odisha. It becomes necessary to assess the impact of the NRHM on the health indicators, to know how the schemes under NRHM are working in Odisha and to assess the transition in the health status of Odisha. Both primary and secondary data are used for the analysis of data. Primary data was collected through personal interviews. Multiple Regression Analysis was used to know how the State Government Capital Expenditure (SGCE) and State Government Revenue Expenditure (SGRE) on health and family welfare have influenced the health indicators like infant mortality rate, birth rate, death rate, etc.

**Amit M Prasad (2013)**[14] public health in India is the responsibility of provincial governments. In 2005, the Indian Government launched the National Rural Health Mission (NRHM) to focus on bottom-up planning and flexible funding to address the local needs. We assessed the effect of interventions introduced under the NRHM on childbirth health services and outcomes in states with poor health indicators. We extracted data for infant mortality rate and total fertility rate from sample registration surveys done in 2001, 2005, and 2011. We also extracted data for institutional deliveries and availability of infrastructure and human resources from the National Family Health Survey III (2005–06), the Annual Health Survey (2010–11), and Rural Health Statistics (2012). The NRHM provides a model to efficiently provide health care to people in low-resource settings.

**Brij Pal (2011)**[15] - The National Rural Health Mission aims at providing accessible, affordable, effective, accountable, and reliable healthcare to all citizens and in particular to the poorer and vulnerable sections of the population; consistent with the outcomes envisioned in the Millennium Development Goals and general principles laid down in the National and state health policies. This programme has put rural public health care firmly on the agenda, and is on the right track with the institutional changes it has wrought within the health system. The present paper seeks to evaluate the performance of service delivery in rural public health facilities under National Rural Health Mission. The concept and working of NRHM has been discussed in brief. The historical development of health services in Indian context has been explained. The problems and challenges being faced in the implementation of this programme are highlighted.

**Kuldeep Kumar (2010)**[16] conducted a study in the State of Uttar Pradesh, India. Uttar Pradesh has been identified as one of the low performing states, both in terms of health system indicators and health outcome parameters. The study was carried out during March, 2009 to August, 2009. From the analysis it is evident that service delivery capacity of the public health system has increased at each level. It is also found that Outdoor Patient visits have increased at all three levels, though with variation. The maximum improvement is found at the PHC (129%) level followed by almost similar increase (86%) at the district and CHC level. We therefore conclude that NRHM

appears to be a well-designed program and lots of thought process has gone into it prior to its implementation. However, it would be too early to predict its outcome in terms of success or failure.

**Mukherjee Srabanti (2010)**[17] Identifying the relevance of healthiness in the course of economic and social advancement and elevating the quality of life of our rural citizens, the Government of India has set on to initiate the National Rural Health Mission (NRHM) to carry out crucial correction in our basic health care delivery network in the rural expanses. The aim of the Mission is to perk up the availability of and access to improved health care facilities by people residing in rural areas especially the vulnerable section, viz. the poor, women and children. This paper attempts to analyze the effectiveness of NRHM in terms of each of these goals and also overall effectiveness of the mission. The paper concludes that NRHM has created very moderate momentum in improvising the rural health care framework, however due to the inefficiencies in terms of infrastructure, health manpower, implementation of AYUSH, lack of penetration of health insurance; it cannot be concluded as 100% effective.

**Kaveri Gill (2009)**[18] in her paper seeks to evaluate quantity and quality of service delivery in rural public health facilities under NRHM. On appropriate and feasible measures, the former is assessed on the static and dynamic condition of physical infrastructure; by the numbers of paramedical, technician and medical staff employed, as well as figures for attendance and gender breakdown; by the supply, quality and range of drugs; by availability and usage of decentralized untied and maintenance funding of centers; and by actual availability of laboratory, diagnostic and service facilities. Quality is defined in relation to the condition of the above tangibles, as also supplemented by subjective data on intangibles, such as patient satisfaction, gathered from the exit interviews. The NRHM has put rural public health care firmly on the agenda, and is on the right track with the institutional changes it has wrought within the health system. True, there are problems in implementation, so that delivery is far from what it ought to be. On physical infrastructure, medicines and funding, procession problems might be more easily scaled with time, whereas on human resources, and to the extent these impacts actual availability of services, structural issues of some complexity need careful resolving with a definite long-term investment in the training and education of paramedical and medical staff, especially women, and close monitoring of attendance. However,

the parameters of the question this study seeks to answer are very much within the ambit of how-to better performance under the NRHM, and not whether the Mission ought to have been undertaken in the first place, of which there can be no doubt.

**Anant Kumar (2008)[19]** People's health and well-being are considered as one of the major indicators of development. In Jharkhand, if this indicator is used, then its level of development leaves much to be desired. The state is confronted with many grave challenges in the health sector. A sizeable share of population remains deprived of basic health care facilities despite the National Rural Health Mission (NRHM) and other health initiatives by the government and related agencies. The issues of availability, accessibility, acceptability, affordability and quality with regard to health care remain as serious concerns. 'Double burden of diseases' has further aggravated the problem together with escalating cost of health care and collapse of state support. The solution is to make the public health system accountable, affordable and accessible by improved management of resources and community action.

**M V Ramana Murthy (2008)[20]** Mobile technologies are increasingly growing in developing countries like India. There have been several new researches and developments in this space. Nowadays mobile is becoming an important ICT tool not only in urban regions but also in remote and rural areas. The rapid advancement in the technologies, ease of use and the falling costs of devices, make the mobile an appropriate and adaptable tool to bridge the digital divide. This paper explores the present status of Mobile based Health Care systems in different countries, shortfalls in Primary Health Care Management in rural India, and the potential solution to fill it with the enabling of Mobile Web technologies for Primary Health Care management.

**C. Lahariya, H. Khandekar, J.G. Prasuna &. Meenakshi (2007)[21]** National Rural Health Mission (NRHM) has been envisaged as a focal point of all the programs targeted to improve the health of people in rural India. It has been widely debated both, before and after the implementation. Ongoing corrective measures and performance appraisal are integrated with this program. No government program was as meticulously prepared or planned as NRHM since Independence. The key functionary of this program, Accredited Social Health Activist (ASHA), a voluntary worker, incorporates all the good qualities of previous similar functionaries in various programs. The active

involvement of Panchayati Raj Institutions (These Panchayati Raj Institutions or PRIs, as they are known here, are the institutions for local self-government where locally elected representatives make decision for the people in the area. The PRIs have been formed at every village level throughout the country.), community (The involvement of community ensure that people decide for themselves to increase their participation in the programs), (Non-Government Organizations (NGO), and Private Practitioners are welcome steps.

**Poornima Vyasulu and V. Vijayalakkshmi (2006)**[22] The study presents an analysis of the reproductive health care services available to women in rural areas in Karnataka, and the various factors influencing them. The study analyzes the status of reproductive health services, their access and reach. The study also examines the role of Panchayati Raj Institutions in providing these services. Three sets of explanatory variables are used to examine maternal health care seeking viz. institutional structure (which includes coordination between the institutions of local government and the health department, the services available at different levels, the network, and availability of funds) quality of services; and social factors. The findings indicate that the resources available for health care are meager, particularly to Reproductive and Child Health (RCH) in rural areas.

## 3.0 RESEARCH GAP

These reviews bear out the position of maternal mortality and condition of government's National Health mission. So far studies have been done in this area, but after in-depth review of previous literature, the researcher has selected the areas which have not been focused yet. The study of NHM with the consideration of SDG 3 which is good health and well-being, have not been discussed in earlier studies. Uttar Pradesh has been lower rank state in Maternal Health status, still no light is thrown in this area by any study.

This study with the aim of highlighting scenario of health status in UP, will be helpful in improving the rank in the field of Good health and well-being of citizens of Uttar Pradesh.

## 4.0 NEED OF THE STUDY

India has a complex healthcare system due to mixed ownership patterns, different types of providers and different systems of medicine. Unfortunately, the distribution of healthcare is uneven, where bulk of the service is available in urban areas and is dominated by the private sector. Improving

maternal health is critical to saving the lives of hundreds of thousands of women who die due to complication from pregnancy and childbirth each year. Maternal and child mortality and morbidity are considered key health indicators as they reflect the state of female healthcare. Increasing access to and utilization of health care services is not sufficient for improving maternal health outcomes. The quality of care a woman receives during pregnancy, delivery and postpartum affects her health, the health of her child and the likelihood that she will seek care in the future.

**Uttar Pradesh is one of the most populous states in India with a huge population and one of the highest maternal mortality ratios (MMR). Thus, this study will enlighten the unfocused arena of the state in these aspects in tune of SDG-3. It will acknowledge the National Health Mission and its utilization in the State of Uttar Pradesh.**

## 5.0 OBJECTIVES OF STUDY

The objectives of the proposed study are as follows:

- To study the prevailing Health Policies and Programs of Government of India in general and Maternal Health in particular in requirement of SDG
- To study the rationale, policy, procedure and budget of National Health Mission in the country.
- To study the present health scenario in Uttar Pradesh in tune of SDG.
- To analyze the contribution of NHM in UP's health scenario with reference to Maternal Health.
- To provide the suggestive action plan for effective utilization of the NHM in the state to meet the targets of SDG-3.

## 6.0 HYPOTHESES OF THE STUDY

Ho 1: There is no significant relationship between Good Health and Well- Being and overall development of a nation.

Ho 2: There is no significant relationship between National Health Policy (or National Health Mission) and Good Health and Well- Being in a nation.

Ho 3: There is no significant impact of Health Policy, infrastructure on Good Health and Well-Being in a state like Uttar Pradesh.

Ho 4: There are no significant gaps between existing Health policy, infrastructure and financial aspects and target regarding MMR, mentioned in SDG-3.

## 7.0 RESEARCH DESIGN AND METHODOLOGY

### 7.1 SOURCES AND TOOLS OF DATA COLLECTION

The nature of study is such that it requires both primary as well as secondary data. In order to achieve the objectives of the study primary data pertaining to selected District Hospitals, Community Health Centre, Public Health Centre, Sub Centre and household beneficiaries will be collected with the help of questionnaire on the basis of stratified random sampling. The present empirical study deals with evaluation of performance of National Health Mission and National Rural Health Mission in Uttar Pradesh in respect of SDG 3 regarding MMR.

Researcher will use secondary sources such as published reports and documents from different institutions, authorities, books, extracts of journals, research papers and other online resources that are relevant to the study.

### 7.2 DURATION OF THE STUDY

This study will take into consideration a period of 17 years i.e. from 2006 to 2022. NHM scheme was started in 2005 that is why researcher started this study from 2006.

### 7.3 SCOPE

From the declared SDGs, researcher has selected SDG 3 Good Health and well-being. There are various targets under SDG-3, the target of Maternal Mort rate (3.1) is considered in this study. For this purpose, National Health Mission will be analyzed in Uttar Pradesh.

### 7.4 UNIVERSE

Officials and authorities and Beneficiary related to National Health Mission and Uttar Pradesh Health Services of Agra District will comprise the universe of this study.

### 7.5 SAMPLE AREA & SIZE

The table no 1 is giving the blocks wise number of villages in Agra district. These blocks are spread over in 6 Tehsil of Agra district. For the study purpose, the researcher will select 3 those villages rank 1 to 3 population wise (according to the census of 2021 or 2011, which is latest at the

time of survey.) from each Block of Agra district. Thus, the study will be conducted in 45 villages out of 905 villages spread over in 6 tehsil and 15 blocks in Agra District.

Regarding the size of the respondents, 1500 beneficiaries (irrespective of caste, creed, etc.) will be selected randomly from each selected village for survey purpose. **Respondent will be selected as per the proportion of population of villages.**

**Thus, the study will be conducted with 1500 persons from 45 villages of Agra District.**

**Table No. 2: Showing the numbers of villages of Agra district (Block wise)**

| Sr.No. | Block | No of village | No of villages selected |
|---|---|---|---|
| **1** | Fatehpur Sikri | 73 | 3 |
| **2** | Achenera | 64 | 3 |
| **3** | Akola | 41 | 3 |
| **4** | Bichpuri | 33 | 3 |
| **5** | Baroli Ahir | 65 | 3 |
| **6** | Khandoli | 47 | 3 |
| **7** | Etmadpur | 61 | 3 |
| **8** | Jagner | 46 | 3 |
| **9** | Kheragarh | 47 | 3 |
| **10** | Sainya | 54 | 3 |
| **11** | Samsabad | 71 | 3 |
| **12** | Fatehabad | 95 | 3 |
| **13** | Pinahat | 52 | 3 |
| **14** | Bah | 80 | 3 |
| **15** | Jaitpur Kalan | 76 | 3 |
| | **Total** | **905** | **45** |

Source: CDO, Agra.

The appendix is giving the name of villages, block wise of Agra district.

## 7.6 VARIABLE OF THE STUDY

The researcher finds the number of variables that are divided into dependent and independent variables. The NHM has been working on declining Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR) and Total Fertility Rate (TFR). It has also achieved many of the disease control targets. Figure 1 below is showing the same.

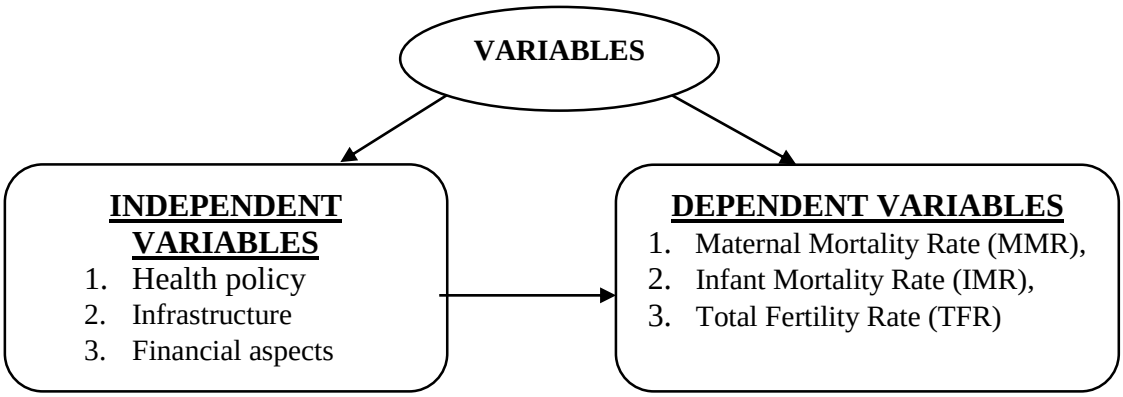


**Figure 1 List of Variables**

## 7.7 STATISTICAL TOOL FOR ANALYSIS

The present study is both quantitative and qualitative in nature. Thus, it requires both types of statistical techniques i.e. Descriptive and inferential Statistics to get the best reliable results and inferences. Various tools like mean, median, Regression analysis, etc. will be used for the analysis of the data.

## 7.8 RESEARCH METHODOLOGY

**Table No. 3: Showing the research methodology with objective wise**

| OBJECTIVES | METHODOLOGY TO BE FOLLOWED |
|---|---|
| To study the prevailing Health Policies and Programs of Government of India in general and Maternal Health in particular.<br>To study the rationale of National Health Mission in the country. | For achievement of first two objectives, researcher will use reports and documents of government websites and other authentic institutions to know the numerous programmes and policies from 2006 to 2022 of central and state level. |
| To analyse the policy, procedure and budget, of NHM. | The official website of NHM and reports related to SDG and NHM will be studied to know the background and implementation procedure, budget allocations and other policies of NHM. |
| To study the present health scenario in Uttar Pradesh in tune of SDG-3. | For achieving this objective, the researcher will collect the information from the different officials' website and reports regarding health care facilities and current scenario in the state. |
| To analyse the contribution of NHM in UP's health scenario with reference to Maternal Health. | Survey will be conducted to collect the required information through a structured questionnaire from the beneficiaries from selected villages of Agra District.<br>The personal interviews of the government officials will be used to ratify the secondary information in this regard.<br>Desired statistical and econometrics tools will be applied to test formulated hypotheses to draw the reliable inferences. |
| To provide the suggestive action plan for effective utilization of the NHM in the state to meet the targets of SDG-3. | Based on the analysis, an action plan of suggestive measures will be formulated which can be helpful in effective implementation of NHM in the state. |

## 8.0 PROPOSED CHAPTER PLAN OF THE STUDY

Chapter 1: - An Introduction of Study

- Health Policies and Programs in India in Past and Present
- National Health Mission
- Overview of SDG 3

Chapter 2: - Review of Literature, Research Gaps and Need of Study

Chapter 3: - Research Design and Methodology, Profile of Uttar Pradesh and Agra District

Chapter 4: - Data Analysis and Testing of Hypotheses

Chapter 5: - Results and Findings

Chapter 6: - Conclusion and Suggestions

## REFERENCE


1. Suhad Daher-Nashif and Hiba Bawadi (2020), "Women's Health and Well-Being in the United Nations Sustainable Development Goals: A Narrative Review of Achievements and Gaps in the Gulf States", Int. J. Environ. Res. Public Health 2020, 17, 1059; doi:10.3390/ijerph17031059.
2. Anuska Kalita, Sachin Shinde and Vikram Patel (2015), "Public health research in India in the new millennium: a bibliometric analysis", Published in Global Health Action 14 August 2015.
3. Mohammad Baharuddin, Dwirani Amelia, Stephanie Suhowatsky, Ary Kusuma, Mohammad Hud Suhargono, and Benjamin Eng, "Maternal death reviews: A retrospective case series of 90 hospital- based maternal deaths in 11 hospitals in Indonesia" Int J Gynecol Obstet 2019; 144 (Suppl. 1): 59–64.
4. Tadele Girum and Abebaw Wasie (2017), "Correlates of maternal mortality in developing countries: an ecological study in 82 countries", Maternal Health, Neonatology, and Perinatology Girum and Wasie.
5. Melissa Bauserman, Adrien Lokangaka, Vanessa Thorsten, Antoinette Tshefu, Shivaprasad S Goudar, Fabian Esamai, Ana Garces, Sarah Saleem, Omrana Pasha, Archana Patel, Albert Manasyan, Mabel Berrueta, Bhala Kodkany, Elwyn Chomba, Edward A Liechty, K Michael Hambidge, Nancy F Krebs, Richard J Derman, Patricia L Hibberd, Fernando Althabe, Waldemar

A Carlo, Marion Koso-Thomas, Robert L Goldenberg, Dennis D Wallace, Elizabeth M McClure, Carl L Bose(2015), " Risk factors for maternal death and trends in maternal mortality in low- and middle-income countries: a prospective longitudinal cohort analysis", Bauserman et al. Reproductive Health 2015, 12(Suppl 2):S5 http://www.reproductive-health-journal.com/content/12/S2/S5.

6. Lale Say, Doris Chou, Alison Gemmill, Özge Tunçalp, Ann-Beth Moller, Jane Daniels, A Metin Gülmezoglu, Marleen Temmerman, Leontine Alkema(2014), " Global causes of maternal death: a WHO systematic analysis",www.thelancet.com/lancetgh vol 2 june 2014.
7. Nizamuddin Khan, Manas Ranjan Pradhan(2013), " Identifying Factors Associated with Maternal Deaths in Jharkhand, India: A Verbal Autopsy Study", J HEALTH POPUL NUTR 2013 Jun;31(2):262-271 ISSN 1606-0997 | $ 5.00+0.20.
8. Nancy L. Sloan, A. Langer, B. Hernandez, M. Romero, & B. Winikoff (2001), "The etiology of maternal mortality in developing countries: what do verbal autopsies tell us?''", Bulletin of the World Health Organization, 2001, 79: 805–810.
9. A. K. Sharma (2018), "Sociological Critique of the National Rural Health Mission: Issues and Priorities", A. K.Sharma, Professor, HSS Department, IIT Kanpur, Kanpur – 208016 Email: arunk@iitk.ac.in
10. Mrs. Balamani V K (2018), "Impact of National Rural Health Mission-A Kerala Health Model", Indian Journal of Research Volume 7 | Issue-1 | January-2018 | PRINT ISSN No 2250-1991.
11. Madhu Gupta1, Hans Bosma, Federica Angeli, Manmeet Kaur, Venkatesan Chakrapani, Monica Rana and Onno C.P. van Schayck (2017), "A mixed methods study on evaluating the performance of a multi-strategy national health program to reduce maternal and child health disparities in Haryana, India", BMC Public Health (2017) 17:698 DOI 10.1186/s12889-017-4706-9.
12. Zakir Husain (2014), "Health of the National Rural Health Mission", Economic and Political Weekly.

**13.** Suresh Kumar Patra D. Satyanarayan Murthy Subhrajit Rath(2013), "An Evaluation of the National Rural Health Mission (NRHM) in Odisha", Article in Journal of Health Management · September 2013.

**14.** Amit M Prasad, Salima Bhatia, Ritu Agrawal (2013), " The effect of the National Rural Health Mission on health services and outcomes for childbirth in India: a retrospective analysis of survey data", Published Online October 20, 2013 Oil India, New Delhi, India (A M Prasad MPS); Ministry of Health and Family Welfare, Government of India, New Delhi, India (A M Prasad, S Bhatia MSc); and UNICEF India Country Offi ce, New Delhi, India (R Agrawal MBBS).

**15.** Brij Pal (2011), "National Rural Health Mission: Issues and Challenges" - Zenith International Journal of Business Economics & Management Research Vol.1 Issue 3

**16.** Kuldeep Kumar (2010), "An Analysis of Utilization of Health Services Under National Rural Health Mission: A Case Study of a Selected District of Uttar Pradesh".

**17.** Mukherjee Srabanti (2010), "A Study on Effectiveness of NRHM in Terms of Reach and Social Marketing Initiatives in Rural India", European Journal of Scientific Research, ISSN 1450-216X Vol.42 No.4 (2010), pp.587-603.

**18.** Kaveri Gill (2009), "A Primary Evaluation of Service Delivery under the National Rural Health Mission (NRHM)", Working Paper, Planning Commission of India.

**19.** Anant Kumar (2008), "National Rural Health Mission and Access To Health Services: Issues And Challenges", Jharkhand Journal of Development and Management Studies, XISS, Ranchi, Vol. 6, No.3.

**20.** M V Ramana Murthy (2008), "Mobile Computing and Wireless Networks – CDAC", Electronics city, Bangalore.

**21.** C. Lahariya, H. Khandekar, J.G. Prasuna & Meenakshi (2007), "A critical review of National Rural Health Mission in India", The Internet Journal of Health. Volume 6 Number.

**22.** Poornima Vyasulu and V. Vijayalakkshmi (2006), "Reproductive Health Services and Role of Panchayats in Karnataka".

**WEBSITES**

- nhm.gov.in , upnrhm.gov.in , www.ncbi.nlm.nih.gov

**APPENDIX**

| S.NO. | NAME OF BLOCK S | NAME OF VILLAGES |
|---|---|---|
| **1.** | **KHANDAULI** | Sorai, Hazipur Khera, Parwatpur, Pant Khara, Sarai Day Ruppa, Madan Pur Must, Gijauli Must,Dhangrauli Must, Khandauli, Ramnagar Khandauli, Malupur, Ujrai, Kheriya Khandauli, Khandia, Nekpur,Bailoth, Naharra, Baman, Semra, Khanda, Bandhanu, Roopdhandu, Pesai, Kharagpur, Parihar, Chaukra, Anwal Khera, Seora, Usmanpur, Sherkhan, Uncha, Agarpur, Mundi Jahangirpur, Hasanpur, Nadau,Poiya, Dhorau, Gurha, Chaugan, Bhagupur, Kuberpur, Dhaurra, Rahan khurd, Rahan kalan, Raipur, Gadpura.<br>**TOTAL NUMBERS- 47** |
| **2.** | **ETMADPUR** | Jamalnagar bhains, Jampur, Sujanpur, Chamraula, Amanabad, Tehu, Nagla Sarup, Yusufpur, Hasan Jahanpur, Saifuddinpur, Jaganpur, Murthar Alipur, Aharan, Nagla Kuwar Janubi, Nagla Kuwar Shumali, Kharkana, Sihorgarh, Mubarkpur Nidhauli, Chuharpur, Mohisinabad, Nagla Beal, Biruni, Kheri Aru, Jamnipur, Kurgawan Khokar, Nagla Mahasingh, Barhan, Nagla Pachauri, Murlidharpur, Chirhauli, Chaoli, Mahabatpur, Nagla Gol, Mukhwar, Benai, Sarai Jairam, Arela, Bahrampur, Garhibachchi, Nagla Nishankh, Nagla Mani, Garhi Pirthi, Nayabans, Biharipur, Nagla Tulsi, Lakhna Mai, Surehra (Must.), Mitaoli, Siktara, Dharera, Talab Buriya, Bhikanpur Bakarpur, Nawalpur, Sanwai, Tamanchgarh, Nagla Sirji, Agwarkhas, Rasulpur, Nagla Bari,<br>**TOTAL NUMBERS-61** |
| **3.** | **BICHPURI** | Bainpur Mustkil, Babarpur Mustkil, Swami Mustkil, Deoretha, Sucheta, Artauni, Kalwari, Albatia, Patholi, Basua Nagla, Khaspur Mustkil, Sikandarpur Mustkil, Tapara, Bamrauli Ahir, Jakhoda, Sadarban, Dehtora, Lakhanpur, Bichpuri, Jaupura, Chauhatna, Manghatai, Mohammadpur, Sunari, Garhsani, Barara, Khallauwa, Sutendi, Laramada, Nanpur, Sahara, Midhakur, Angoothi.<br>**TOTAL NUMBERS- 33** |
| **4.** | **AKOLA** | Jain Gara, Baman, Basaia Raimol, Basia Jotiraj, Ikram Nagar, Naraul, Basai Bobla, Salemabad, Chainkora, Bamanpura, Nahchani, Davli, Sagunapur, Baroda Sadar, Karahara, Nagla Sikarwar, Maniyan, Jitora,Ujarai, Kheria, Gahara Kalan,Akhbai, Rithaura, Gahara Khurd, Baha,Basarai Chahar, Gamari, Bain Khera, Malpura,Khera Bhagor, Jarua Katra, Mundhera, Siroli,Abhaypura, Balhera, Akola, Mankenda, Lalau, Khal, Pinani Ramnagar.<br>**TOTAL NUMBERS- 41** |
| **5.** | **AHIR** | Bhandai, Kakua, Rampura, Salemabad, Kaboolpur, Bad, Kuthawati, Itaura, Rohta, Saimari, Pachgain Khera, Patti Pachgain, Nainana-Brahman, Kaulakha, Chak Vi Chor Nagaria, Chamrauli, Bagda, Barauli Ahir, Rajrai, Kalika Nagla, Naubari, Gutla, Kahrai, Deori, Gangraua, Bajhera, Sujgai, Bishara Kalan,Digner, Akbarpur, Brahmnagar, Shyamo, Lodhai, Nauphari, Pawawali, Nagla Nathu, Islampur, Lakavali, Kalal Kheria, Budhera, Mayapura, Bamrauli Katara, Ikthara, Hingot Kheria, Bijhamai, Karmana Mustkil, Budhana Mustkil, Tora, Kuan Khera, Mahua Khera, Etmadpur Madra, Samogar Mustkil, Sargan Khera, Tanora Nurpur Mustkil, Bilahani, Sarvatpur, Mehra Naharganj, Barauli Gujar, Bishari Bhand, Janara, Kundol, Nadauta, Bisarna, Dhamota, Ikthara.<br>**TOTAL NUMBERS- 65** |
| **6.** | **FATEHPUR SIKRI** | Undera, Deonari, Sika Rauda, Mai Bujurg, Dulhara, Gujarpura, Badanpur Barnabai, Sunhara, Gurki Mandi, Nurpur, Korai, Nagla Baharwati, |

| | | |
|---|---|---|
| | | Ninbaya, Jajav, Malikpur, Bharhkol,Suphaera, Baharabati Khas, Singarpur, Santha,Daultabad, Naya Bass, Basari Sikandar, Tajpur,Gothara, Panchakki, Baseri Kazi, Imlabada, Mandoli, Khanpur Nithari, Surodhi, Rasulpur Kiraoli, Karahi, Ghorali, Churiyari, Dadukara,Chauma Shahpur, Patsal, Mahdav, Pali Kiraoli,Sikri Hissa Iv, Nagirpura, Doora, Teekri, Didhwar, Arhera, Deorentha, Sarsa, Rojauli,Banpur, Samara, Daudpur, Uttu, Ghauroli,Sahanpur, Mohammadpur, Nagla Sarai, Jajauli,Sonothi, Bandrauli, Sirauli, Mandi Mirza Khan, Khera Jat, Aulenda, Jautana, Jahanpur, Bho Pur, Dabar, Tehra Rawat, Mangoli Kalan, Mangoli Khurd, Hanspura, Nagla Mangoli.<br>**TOTAL NUMBERS- 73** |
| **7.** | **ACHHNERA** | Hansela, Tirpuri, Gobra, Bhandiri, Mori, Barauli, Mangarol Gujar, Puramana, Mangaroli Jat, Ardaya, Gadi Candarman, Biara, Basaia Rajput, Fatehpura, Nagla Arua, Arrua Khas, Abhaudopura, Kukathala, Bastai, Kachaura, Anganpur, Mubarikpur, Rampur, Babrod, Khera Sadhan, Sandhan, Loh Karera, Raipura Ahir, Garhima, Panwari, Akabara, Singma, Chauma Farah, Jugsana, Arsena, Runkata, Bhilawati, Jharoti, Turkia, Sahri, Rasulpur Sadar, Mahuar, Jakha, Pali Sadar, Sehta, Raibha, Thapi, Mangura, Janutha, Nagar, Bidhapur, Atus, Dhanoli, Kharbai, Khera Bakanda, Gurha, Kitham, Muranda, Kathawari, Sakatpur, Nanau, Mai, Kasoti, Chhae Pokhar, Gopau.<br>**TOTAL NUMBERS- 64** |
| **8.** | **JAGNER** | Singaicha, Usarra, Nagla Kasimpur, Chandsora, Dahgawan, Bargawan Buzurg, Shahpur Jagner, Pipretha, Nimena, Meoli, Meola, Udena, Nagla Virbhan, Jheetpura, Nauni, Sarendhi, Richhoha, Tarhat, Deori, Jagner dehat, Bamnai Khurd, Bamnai Kalan, Bhawanpura, Bidhouli Jagner, Basai Jagner, Karhaki, Singrawali, Shahganj, Kondari, Soni Khera, Bazidpur, Kathumari, Bhopur Jagner, Thansera, Tantpur, Baghour, Ghaskata, Garhi Karimpur, Gugawand, Chachond, Dhanina, Bhara, Gulabganj, Nayagaon, Barigwama khurd, Sarai Ahmad.<br>**TOTAL NUMBERS- 46** |
| **9.** | **KHERAGARH** | Digrauta, Beesalpur, Bishrampur, Cheetpur, Rithori, Beri Chahar, Gorau, Bhilawali, Cheet, Aurangpur, Bakalpur, Bhojpur, Bidhauli Kheragarh, Kagarol, Ata, Bhopur Kheragarh, Danda, Rasulpur, Nagla Duleh Khan, Patparganj, Ghusiana, Sitouli, Burhera, Bhaker, Khanpur, Untgiri, Lakhanpura, Kentholi, Soun, Shahpur Rakauli, Salahnagar Barbar, Chandi, Kukandai, Dungarwala, Kulhara, Pai Ghusiyan, Sarenda, Dankasa, Mahua Khera, Basai Kheragarh, Bhenson, Roodhau, Lalpur, Pairatia,Ayela, Pahadi Kalan.<br>**TOTAL NUMBERS- 47** |
| **10.** | **SAIYAN** | Murkia, Bisahara, Jonai, Biraharu, Kukawar, Sikandar Pur, Siarmau, Tehra, Lahchora, Birai, Taharpur, Chitapur birai, Chitapur Motipura, Sonra, Jajau, Saiyan, Nadim, Rajpura, Mohanpur, Shahpur nadim, Mukhrai, Hironda, Nagla Mohare, Garsan, Brithala, Ladukhera, Silokhar, Mai, Pachmori, Garhi Ahir, Khedia, Nagla Inami, Panota, Sekhpur Nagla, Raghupura, Noharika, Mahao, Basai Kalan, Basai Khurd, Iradat Nagar, Goharra, Babarpur, Sherpur,Rahalai, Pusenta, Mahdewa, Darki,Chhattapura, Sadupura, Thapenra, Bhipawali, Mihawa, Motipura, Mangalpur Bantara.<br>**TOTAL NUMBERS- 54** |

| | | |
|---|---|---|
| **11.** | **SAMSABAD** | Mubarikpur, Singaicha, Surajpura, Usara, Gauharpur, Karahi, Tondra, Kurra Chitterpur, Seola Ahir, Gadoli Kalan, Gadoli Khurd, Lakhanpur, Nagla Patam, Dabari, Lakhurani, Isauli, Loheta, Tor, Thap Khargh, Lohari Iradatnagar, Thap Mahadwari, Karaudhna, Therai, Bisauri Gaurwa, Gadhi Shripati, Phulpur,Inayatpur, Lahara, Bakalpur, Siktara, Nagla Bhikki, Mirpur, Patti Shaikhupur, Shekhupur, garhi sakkan, Banguri, Pauser, Kolara Kalan, Gurha, Mutnai, Uncha, Chitaura, Kolara Khurd, Barobara Khurd, Sudhrai, Jarauli, Muzaffarpur, Patti Muzaffarpur, Patti Bhanpura, Lahar Patti, Thana Shankar Dwari, Maharampur, Shahpur Toola, Gubrari, Himayunpur Rohai,, Etmadpur Ajnera, Barobara Kalan, Qutubpur Rohai, Rohai Khas, Dhanaula Kalan,, Hirner Nawadakhera, Sewala Gorawa, Lakhanpur, Kolari, Doki,Bhanapura, Nagla Shadi, Nagla dhir, kutakpur rohai.<br>**TOTAL NUMBERS-71** |
| **12.** | **FATEHABAD** | Nibohra, Bilpura, Alampur, Salempur Ghankar, Saidpur, Patharkot, Behri, Nagar, Shahved, Nichakhera, Ramgarh, Sarangpur, Qutubpur Gola, Bhikanpur, Jawaharpur, Paliya, Krapal Pura, Arrji Paliya, Basai, Gangaura, Garhi Udairaj, Bhalokhara, Humayonpur Gujar, Khera Jawahar,, Babarpur, Aie, Murawal, Shahidpur, Nagla Haji, Mahra Chaudhri, Jalalpur, Swara, Ruppur, Naugawan, Tiwaha, Nagla Mawai, Luhari Fatehabad, Dhanaula Khurd, Sankuri Khurd, Kutabpur Gujar, Begampur, Silauli, Rihauli, Tarauli Gujar, Sankuri Kalan, Barna, Mewali Kalan, Mewali Khurd, Wazidpur, Penti Khera, Bidrai, Dhimsiri, Kanharpura, Ghaghpura, Baripura, Maraina, Sikrara, Mutawai, Kalayan Pur, Ran Pura, Tas Pura, Salempur Muria, Jagraj Pura, Bichola, Nagar Chand, Behari, Paroli Sikarwar, Himayunpur Edoin, Indon, Bamrauli, Pratap Pura, Bharapur,Gidron, Dhaurra, Chamrauli, Koomppura,, Mohammadpur, Nagariya, Rampura, Jatpura, Raipura, Maharajpur, Musepura, Mithpura, Rasulpur, Fatehabad Rural, Gubrauth, Jarari, Biloni, Khandar, Bhadaura, Ujhaoli, Nagla Lohia, Gari Daryab.<br>**TOTAL NUMBERS- 95** |
| **13.** | **PINAHAT** | Reha, Tasond, Barenda, Paprinagar, Seha, Shahpur Khalsa, Sihpura, Manona, Basai Goojar, Ondh, Karkoli, Manhgoli, Vipraoli, Serab, Arnota, Basai Arela, Mahapur, Manikpura, Sabora, Kherdanda, Milik, Kankar Kheda, Basai Bhadoriya, Bhari Nagla, Pidhora, Rajaura, Balai, Bhitari, Ratauti, Siahipura, Gajoura, Ladhavapura, Bhonigapura, Nagla Dalel,, Husainpura, Sutahari, Lalpura, Modipura, Kukthari, Arjun Pura, Udaypur Khalsa, Jaitpur Khurd, Mitaili, Pinaht Dehat, Sikthara, Utsana,Pundrikpura, Kiyori, Umretha, Baghrena.<br>**TOTAL NUMBERS-52** |
| **14.** | **BAH** | Kwaari, Jarar, Derak, Pratappura, Vrishangpura, Tarson, Mudiyapura, Deenpura, Pharaiyapura, Narholi, Bhaupura, Vijoli, Bhadroli, Itaili, Gopal Pura, Pharairi, Holy Pura, Raipura Bhadoriya, Kalyanpur, Kharagpura, Bitholi, Nagoo Pura, Nagriya, Rampur Chandrasaini, Bateshwar, Vijkoli, Budhera, Kalinjar, Siyainch, Pharaira, Mai, Lakhanpur Khalsa, Padkoli, Hajarpura, Dagroopura, Zebara, Badous, Bamroli, Kunwar Kheda, Gungawali, Abhaypura, Changoli, Renka, Chamraua, Khajuhapura, Bichoula, Neemdanda, Kenjra, Gonsili, Purabhagwan, Simrahi, Gurha, Ranipura, Chousingi, Sannpura, Veri, Silpoli, Purakanera, Indaini, Dodapura, Midkoli, Rajpura, Kanera, Sidhaoli, Mangadpur, Dhobai, Sunsar, Mansoorpura,Kot, Nagla Ent, Hingot Khera, Kheda Devidass, Rudmuli, Vikarampur, Emanpura, Bah Dehat,Basoni, Barha, Mai,Sannpura.<br>**TOTAL NUMBERS-80** |

| | | |
|---|---|---|
| **15.** | **JAITPUR KALAN** | Badagaon, Uganpura, Chorangabehar, Kachhpura, Chandrapura, Nahtoli, Samaramau, Chourangahar, Madhepura, dhaniya pura, Khohri, Khera Rathor, Gohra, Udaypur Kalan,Bedpura, Karanpuri, Richhapura, Karanpura, Keelpura, Mahua, Nadgawan, Devpura, Bithona, Khuliyapura, Raipuradixit, Kyari, Garhi Rampra, Kamtari, Rooppura, Dhaypura, Paharpura, Nonera, Sajaiti, Gadhbar, Charitha, Garhi Baroli, Parana, Sujanpura, Lakhanpura Jahageer, Nagla Bachhgaiyan, Kamalpura, Tilupura, Fatehpura, Jaitpura Kalan, Pyarampura, Vankati, sizwari pura, Amahi, Dharmasala, Madhaiya jaisingh, Shahapur Brahaman, pathak pura, Udhannapura, Kanaharpura, Nayepura, Naugawan, Chitrahar, Pai, Khicharpura, Kachora Ghat, Mukutpura, Kharik, Sarokhipura, Mau, Nawali, Gadhia Pratappura, Kookapur, Khilawali, Shahapur Goojar, Korath, Kamoni, Udaypur Khurd, Maloni.<br>**TOTAL NUMBERS-76**<br>**TOTAL NUMBER OF VILLAGES IN 15 BLOCKS – 905** |